



Senate

General Assembly

File No. 7

February Session, 2014

Substitute Senate Bill No. 10

Senate, March 11, 2014

The Committee on Insurance and Real Estate reported through SEN. CRISCO of the 17th Dist., Chairperson of the Committee on the part of the Senate, that the substitute bill ought to pass.

AN ACT CONCERNING COPAYMENTS FOR BREAST ULTRASOUND SCREENINGS.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

1 Section 1. Section 38a-503 of the general statutes is repealed and the
2 following is substituted in lieu thereof (*Effective January 1, 2015*):

3 (a) (1) Each individual health insurance policy providing coverage
4 of the type specified in subdivisions (1), (2), (4), (10), (11) and (12) of
5 section 38a-469 delivered, issued for delivery, renewed, amended or
6 continued in this state shall provide benefits for mammographic
7 examinations to any woman covered under the policy that are at least
8 equal to the following minimum requirements: (A) A baseline
9 mammogram for any woman who is thirty-five to thirty-nine years of
10 age, inclusive; and (B) a mammogram every year for any woman who
11 is forty years of age or older.

12 (2) Such policy shall provide additional benefits for:

13 (A) Comprehensive ultrasound screening of an entire breast or
14 breasts if a mammogram demonstrates heterogeneous or dense breast
15 tissue based on the Breast Imaging Reporting and Data System
16 established by the American College of Radiology or if a woman is
17 believed to be at increased risk for breast cancer due to family history
18 or prior personal history of breast cancer, positive genetic testing or
19 other indications as determined by a woman's physician or advanced
20 practice registered nurse; and

21 (B) Magnetic resonance imaging of an entire breast or breasts in
22 accordance with guidelines established by the American Cancer
23 Society.

24 (b) Benefits under this section shall be subject to any policy
25 provisions that apply to other services covered by such policy, except
26 that no such policy shall impose a copayment that exceeds a maximum
27 of twenty dollars for an ultrasound screening under subparagraph (A)
28 of subdivision (2) of subsection (a) of this section.

29 (c) Each mammography report provided to a patient shall include
30 information about breast density, based on the Breast Imaging
31 Reporting and Data System established by the American College of
32 Radiology. Where applicable, such report shall include the following
33 notice: "If your mammogram demonstrates that you have dense breast
34 tissue, which could hide small abnormalities, you might benefit from
35 supplementary screening tests, which can include a breast ultrasound
36 screening or a breast MRI examination, or both, depending on your
37 individual risk factors. A report of your mammography results, which
38 contains information about your breast density, has been sent to your
39 physician's office and you should contact your physician if you have
40 any questions or concerns about this report."

41 Sec. 2. Section 38a-530 of the general statutes is repealed and the
42 following is substituted in lieu thereof (*Effective January 1, 2015*):

43 (a) (1) Each group health insurance policy providing coverage of the
44 type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-

45 469 delivered, issued for delivery, renewed, amended or continued in
46 this state shall provide benefits for mammographic examinations to
47 any woman covered under the policy that are at least equal to the
48 following minimum requirements: (A) A baseline mammogram for
49 any woman who is thirty-five to thirty-nine years of age, inclusive; and
50 (B) a mammogram every year for any woman who is forty years of age
51 or older.

52 (2) Such policy shall provide additional benefits for:

53 (A) Comprehensive ultrasound screening of an entire breast or
54 breasts if a mammogram demonstrates heterogeneous or dense breast
55 tissue based on the Breast Imaging Reporting and Data System
56 established by the American College of Radiology or if a woman is
57 believed to be at increased risk for breast cancer due to family history
58 or prior personal history of breast cancer, positive genetic testing or
59 other indications as determined by a woman's physician or advanced
60 practice registered nurse; and

61 (B) Magnetic resonance imaging of an entire breast or breasts in
62 accordance with guidelines established by the American Cancer
63 Society.

64 (b) Benefits under this section shall be subject to any policy
65 provisions that apply to other services covered by such policy, except
66 that no such policy shall impose a copayment that exceeds a maximum
67 of twenty dollars for an ultrasound screening under subparagraph (A)
68 of subdivision (2) of subsection (a) of this section.

69 (c) Each mammography report provided to a patient shall include
70 information about breast density, based on the Breast Imaging
71 Reporting and Data System established by the American College of
72 Radiology. Where applicable, such report shall include the following
73 notice: "If your mammogram demonstrates that you have dense breast
74 tissue, which could hide small abnormalities, you might benefit from
75 supplementary screening tests, which can include a breast ultrasound
76 screening or a breast MRI examination, or both, depending on your

77 individual risk factors. A report of your mammography results, which
78 contains information about your breast density, has been sent to your
79 physician's office and you should contact your physician if you have
80 any questions or concerns about this report."

This act shall take effect as follows and shall amend the following sections:		
Section 1	<i>January 1, 2015</i>	38a-503
Sec. 2	<i>January 1, 2015</i>	38a-530

INS *Joint Favorable Subst.*

The following Fiscal Impact Statement and Bill Analysis are prepared for the benefit of the members of the General Assembly, solely for purposes of information, summarization and explanation and do not represent the intent of the General Assembly or either chamber thereof for any purpose. In general, fiscal impacts are based upon a variety of informational sources, including the analyst's professional knowledge. Whenever applicable, agency data is consulted as part of the analysis, however final products do not necessarily reflect an assessment from any specific department.

OFA Fiscal Note

State Impact:

Agency Affected	Fund-Effect	FY 15 \$	FY 16 \$
State Comptroller - Fringe Benefits	GF, TF - Cost	Less than \$5,000	Less than \$10,000

Municipal Impact:

Municipalities	Effect	FY 15 \$	FY 16 \$
Various Municipalities	STATE MANDATE - Cost	Potential	Potential

Explanation

There may be a potential cost of less than \$5,000 in FY 15 and less than \$10,000 in FY 16 to the state employee and retiree health plan¹ from capping copayments for breast ultrasound screenings at \$20.² The potential cost is attributable to out-of-network ultrasound screenings for members enrolled in the state Point of Service (POS) plans³ and those not currently enrolled in the Health Enhancement Program (HEP)⁴, who fit the screening parameter of the bill. The state plan does not currently impose a copayment for in-network

¹ The state employee and retiree health plan is a self-insured health plan. Pursuant to federal law, self-insured health plans are exempt from state health mandates. However, the state has traditionally adopted all state health mandates.

² The potential cost assumes the average ultrasound screening is approximately \$252. (Source: University of Connecticut, *Review and Evaluation of Certain Health Benefit Mandates in Connecticut*, 2012, p. 198) *Adjusted by medical inflation.*

³ Members enrolled in a POS plan are required to pay 20% of allowable costs after satisfying the plan deductible and 100% of costs charged by the provider in excess of the allowable cost.

⁴ Members not enrolled in the HEP plan must satisfy the plan's deductible for services where there is no cost sharing.

screenings. The vast majority of members use in-network services.

The bill's cap on copayments for ultrasound screenings may increase costs for certain fully insured municipalities which require member cost sharing in excess of \$20. The coverage requirements may result in increased premium costs for the municipality when they enter into new health insurance contracts after January 1, 2015. Due to federal law, municipalities with self-insured plans are exempt from state health insurance mandates.

Lastly, many municipal plans may be recognized as "grandfathered"⁵ plans under the federal Affordable Care Act (ACA). It is uncertain what the effect of this mandate will have on the grandfathered status of those municipal plans.

For the purposes of the ACA this bill is not considered an additional mandate and therefore will not result in an additional state cost related to reimbursement for the mandate for those covered through the exchange plans.

The Out Years

The annualized ongoing fiscal impact identified above would continue into the future subject to inflation.

Sources: *Office of the State Comptroller*
Office of the State Comptroller State Health Plan, Plan Benefit Document as of July 2013

⁵ Grandfathered plans include most group health insurance plans and some individual plans created or purchased on or before March 23, 2010.

OLR Bill Analysis**sSB 10****AN ACT CONCERNING COPAYMENTS FOR BREAST
ULTRASOUND SCREENINGS.****SUMMARY:**

This bill prohibits certain health insurance policies from imposing a copayment of more than \$20 for a breast ultrasound screening for which the policies are required to provide coverage. By law, policies must cover a breast ultrasound screening if a (1) mammogram shows heterogeneous or dense breast tissue based on the American College of Radiology's Breast Imaging Reporting and Data System or (2) woman is at an increased risk for breast cancer because of family history, her own breast cancer history, positive genetic testing, or other indications her physician or advanced practice registered nurse determine.

The bill applies to individual and group policies delivered, issued, renewed, amended, or continued in Connecticut that cover (1) basic hospital expenses; (2) basic medical-surgical expenses; (3) major medical expenses; or (4) hospital or medical services, including coverage under an HMO plan. It also applies to individual policies that cover limited benefits. Due to the federal Employee Retirement Income Security Act (ERISA), state insurance benefit mandates do not apply to self-insured benefit plans.

EFFECTIVE DATE: January 1, 2015

COMMITTEE ACTION

Insurance and Real Estate Committee

Joint Favorable Substitute

Yea 19 Nay 0 (02/25/2014)